24 [illegible] 1958

MEMORANDUM FOR THE RECORD

TO : Director of Special Activities

SUBJECT: Reorganization of OSA Medical Staff

25X1A [redacted] proposed a reorganization of the Medical Staff, Physiological Training Office and Survival Group. This projected reorganization was discussed first among all parties directly involved and then at a larger meeting including the Deputy Director, OSA, Chief of Operations, Comptroller, Personnel Officer, Engineering, etc.

As a result of these preliminary meetings it was the consensus that a Aero-Medical Staff be constituted and be placed directly under and reporting to the Director, OSA. The newly created Aero-Medical Staff would have within it the Physiological Training Officer and the USAF assigned survival NCO. These latter moves would require that the PTO be reassigned from R&D and the survival NCO be removed from the Intelligence Section. This conforms to the 25X1A organization at [redacted] and is standard USAF T/O set-up. It is felt by all concerned that these are all related programs concerned with the best possible environmental care of the air crew and by grouping together in one office the mission might be accomplished in the most logical manner and to the highest degree possible.

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There was no complaint from the PTO as to his relationship to R&D but there is the recognition that due to circumstances presently existing there is and will be less R&D on the part of the PTO and the more normal aspects of his job are oriented more towards the Medical Staff. This same thinking applies to the survival trainer and it was universally agreed that the USAF assigned NCO could competently handle the job by himself.

SECRET

It is also felt that because of the small size of this Staff they could better function by being together and being knowledgeable of each others programs so that plans can be coordinated and in the event of any absences due to TDY, etc., the remaining personnel can cover the office. This move will not require any change on the T/O of OSA but only the personnel office action in changing [redacted] to a 25X1A position on the Director's Staff from their present locations.

A functional chart was agreed upon and presented to the preliminary meeting of the Staff. It's general outline was agreed upon and subsequently streamlined. At a meeting in the Director's Conference Room on 17 September 1968 the Director and Staff formally approved this reorganization. A copy of the functional chart is enclosed along with a brief explanatory outline. At a later date more detailed mission responsibility papers will be forthcoming.

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Providing assigned office space and secretarial help are approved, it is recommended that 1 October 1968 be the date of implementation.

25X1A

[redacted]

OSA Medical Officer

Enclosure -
As Stated

25X1A OSA/MO/[redacted]

Distribution:

25X1A Orig & 2 - [redacted]
1 - D/SA
1 - DD/SA
1 - COMPT/OSA
1 - D/R&D/OSA
1 - D/O/OSA
1 - C/SS/OSA
1 - PD/OSA
25X1A 1 - [redacted]
1 -
1 -

SECRET

OUTLINE TO ACCOMPANY FUNCTIONAL CHART
RE NEWLY ESTABLISHED AEROMEDICAL STAFF

1) Staff placed directly under Director for several reasons; one, that privileged medical information have direct access to Director, secondly; that there is no one office that would normally encompass all the diverse functions of this group. TO limitations.

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25X1A 25X1A 25X1 25X1A 25X1C

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A wide variety of medical assets is available and used by OSA. This includes all of Hq Office of Medical Services including its psychiatric and psychological departments as well as outside examining facilities at Rosslyn. The Lovelace Clinic at Albuquerque is used for periodic examinations on pilots. Medical evaluations are provided by the Surgeon General's Office of the USAF utilizing the school of Aerospace Medicine at San Antonio. The S.G.O. can and does also utilize any USAF medical facility as required.

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Training in medical subjects such as First Aid, tropical diseases, is also a function of the medical staff.

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There is also considerable coordination between field and various medical facilities and between permanent base and overseas stations.

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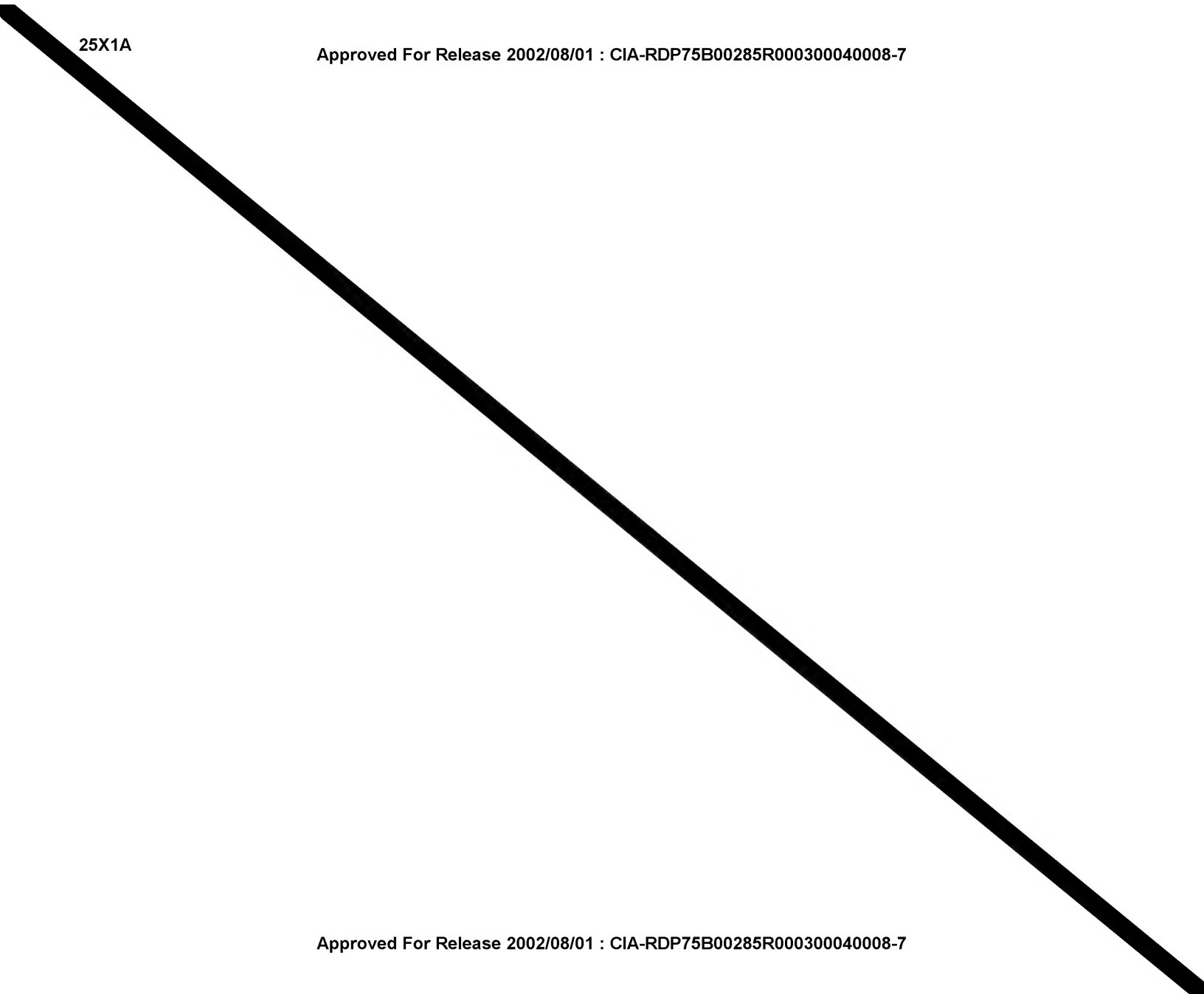
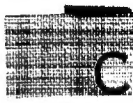
ADDED NOTE:



Approved For Release 2002/08/01 : CIA-RDP75B00285R000300040008-7



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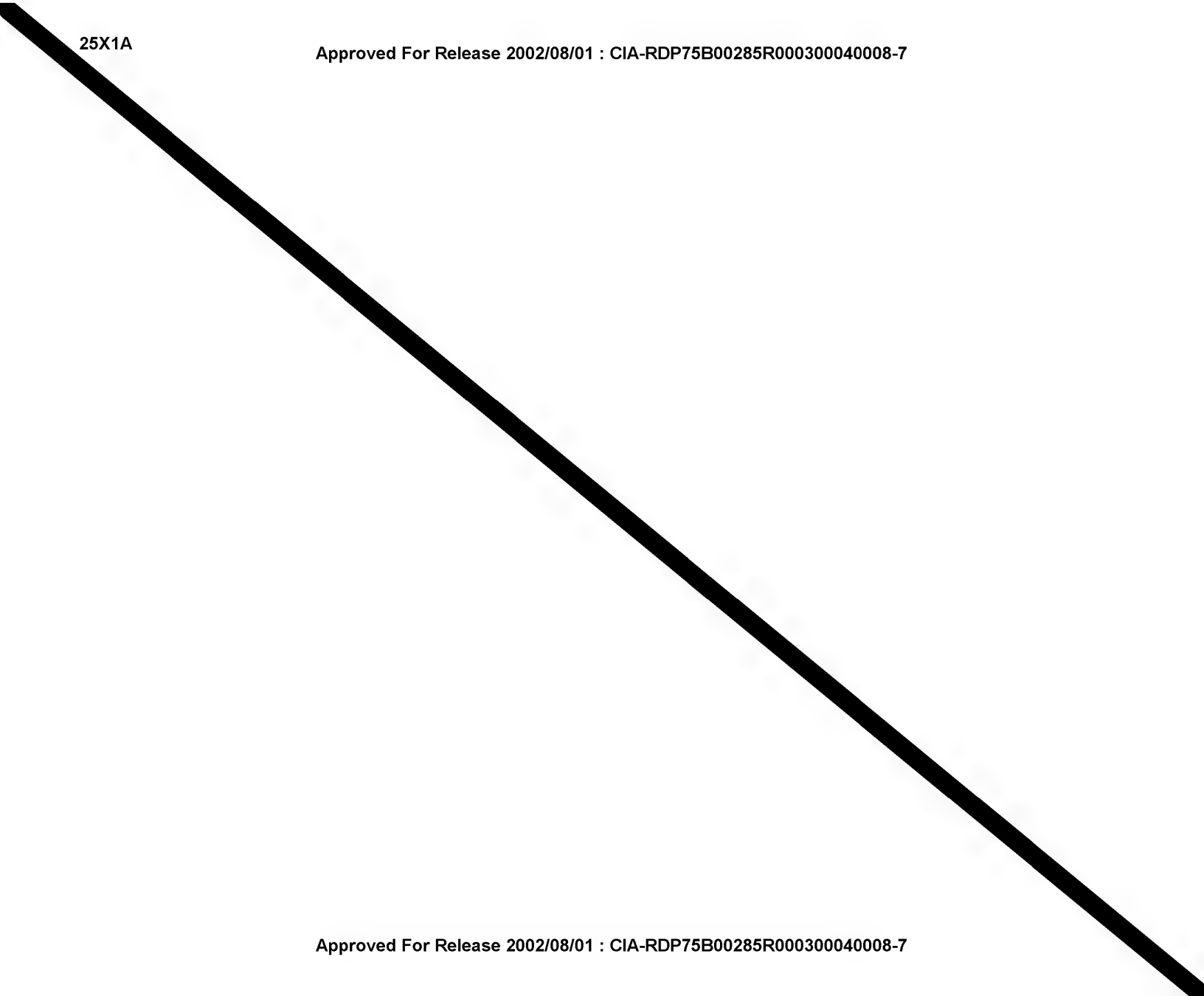

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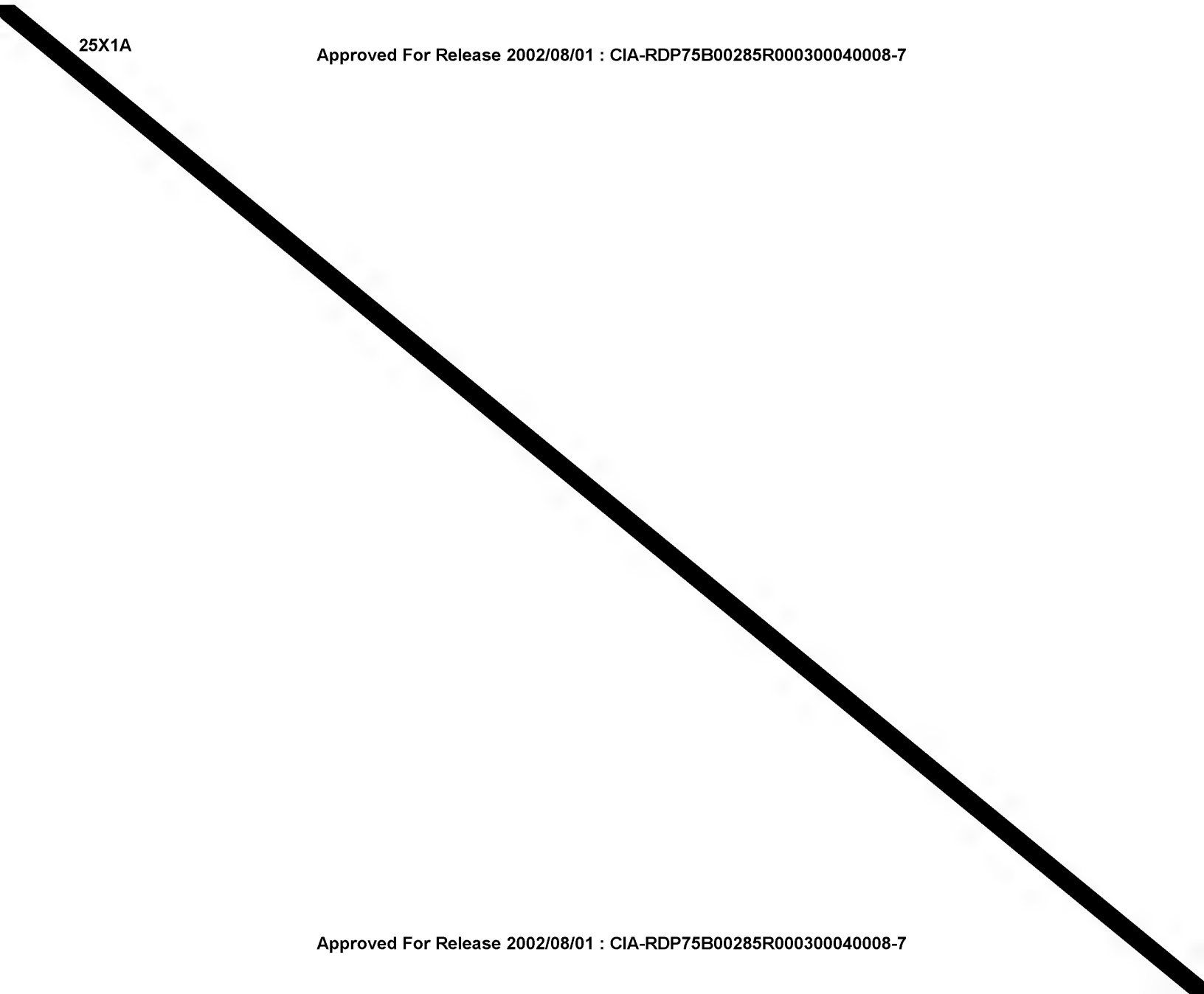

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4 October 1968

MEMORANDUM FOR : OSA Staff - Initial Coordination
USAF-SGO - Final Coordination
USAF-SAD [redacted] Office) - Final Coordination 25X1A

SUBJECT : Activation of Aeromedical Office and Transfer of Responsibilities

A. Past Aeromedical and Life Support responsibilities and activities have not been formally delineated and assigned owing to the rather loose and ubiquitous manner in which the writer operated as a consultant. The basic philosophy upon which the newly organized Aeromed Office was presented and approved provides for a single-point of responsibility and policy making in all Aeromedical and related activities in [redacted] as the Chief Flight-Surgeon, 25X1A OSA. This will provide and insure the proper integration and coordination of all Aeromedical activities within OSA itself and its interrelated governmental and other pertinent organizations. The objective of this communication is basically to provide guidance to those personnel assigned full-time to the OSA-AO arriving at a complete functional breakdown of all responsibilities and activities. Obviously, with the dropping out of some projects and the initiation of new ones, there will undoubtedly be some changes made on past patterns on the part of the CFS and Director, OSA. It should be moved herein, that the specific duties to be carried out by the Aeromedical Consultant have not been spelled out in any greater detail than what appears on the preliminary organization chart appended to memo for record dated 24 Sept 68, subject: "Re-organization of OSA Medical Staff" signed by [redacted] as 25X1A OSA Medical Officer. A final designation of the specific role which our Aeromedical Consultant will play in the over-all aeromedical

activities will be determined at some future time by [redacted] 25X1A and other pertinent OSA and Agency personnel.

B. Recruitment of OSA - assigned personnel (not including contract flying personnel)..

1. Medical personnel: Contacts will be made by the CFS [redacted] with cleared liaison personnel 25X1A in the Office of the Surgeon-General, USAF who will provide named nominees meeting the professional and security criteria designated by OSA. Subsequent processing will proceed according to SOP established by CFS following which he will make final acceptance decision and so notify proper assignment authorities to initiate necessary personnel actions.

2. Non-Medical personnel: Nominees will be processed according to aeromed, psychologic and psychiatric evaluation procedures established by CFS. He will communicate through liaison medical officers in the AF-SGO any requirements for local medical rechecks which may be required after review of personal medical records submitted on the nominee under consideration.
N. B. In this connection it is suggested that an early meeting with the medical liaison officer in the AF-SGO be accomplished for the purpose of establishing mutually agreeable SOP's on the recruitment of both medical and non-medical personnel for OSA duty.

C. Recruitment of aircrew personnel, contracturally or otherwise affiliated with OSA.

1. Current procedures for the screening, processing, evaluation and selection of "operational" personnel are reasonably well-defined and understood but possibly a SOP outlining this entire activity is in order. In the case of AF aircrew personnel under consideration, these procedures, of course, require the closely coordinated activities and cognizance of the D/Ops, C/Personnel in OSA, AF-SAD, AF Personnel [redacted] and AF-SGO. It is well to mention 25X1A in this connection that some thought and effort should be given to working through the AF Surgeon General

toward improving the current standards and procedures now being exercised at Brooks AFB (S.A.M.) in carrying out the aeromedical surveys on volunteers for "special" Aerospace Medical assignments. There has been an obvious deterioration over the past several years in the quality of the "special" aeromedical evaluations being carried out at AFSAM, Brooks AFB, Texas.

2. Current methods and procedures in use to evaluate and select foreign exchange pilots are being carefully reviewed towards the end of achieving significant over-all improvements. These suggested changes have been presented to the Director, OSA and Staff by the CFS and are under consideration currently. When final decision has been reached, a revised SOP for the processing of these types of operational personnel will be prepared by the CFS.

D. Aeromedical Support - I - Medical Evaluation and Maintenance.

1. On-going programs for the maintenance of optimal operator performance through the means of established physiologic and psychological fitness training programs along with periodic medical, psychiatric and psychologic evaluations are in good order. The unit F/S, the Lovelace Clinc Staff and the OSA-AO all have well-defined responsibilities which, in general terms, cover two broad areas of responsibility. The first of these is the primary requirement to continuously follow and critically evaluate all medical psychologic operational and personal data on each individual in order to detect and correct early trends indicative of potential inabilities or impairments in over-all health and operational fitness. The second requirement incumbent upon the "aeromed team" is to constantly review any significant advances in biomedical knowledge and technology which merit serious consideration for inclusion into existing preventive and constructive aeromedical maintenance procedures. Germane

to this latter important area of responsibility is the knowledge that considerable advances are now being made on the National Health Front in such areas as Multiphasic Screening and rehabilitation programs which have personal health and fitness objectives very closely allied to our own.

2. Administrative procedures for the transmission and processing of these types of aeromedical support data will be revised at an early date to fit into the new OSA-AO organizational structure. Pending the formulation of this revised administrative SOP, the writer is consolidating the existing aeromedical data currently reposing in locked files (OSA Personnel Division) according to the new guidelines.

E. Aeromedical Support - II - Medical Operations.

1. Previously established standards and procedures for planning and implementing medical operations at both home and toward bases conform closely to those used in tactical Air Force operations. Certain features in the handling of seriously-ill, injured and fatalities are peculiar to OSA and, therefore, should be coordinated again with other auxillary agencies and re-stated in a formalized SOP. The Operational Flight Surgeon's Manual which was developed and distributed 4 years ago would provide the nominal basis for this particular review and revision exercise.

2. Continuous efforts have been expended in the past to standardize, wherever feasible and practicable, the aeromed procedures and reporting forms between OSA and Air Force "special flying Activities; with only partial success due to the sensitivity of operational parameters on both sides." 25X1A [redacted] feels that, despite these apparent obstacles which have partially impeded our past coordination efforts, we should continue to work toward some degree of commonality in the

recording of significant operational aeromedical data. In the past, we have had periodic meetings between AF and OSA aeromedical people to maintain at least some cognizance and coordination of common problems and practices, all of which has been quite valuable to both parties. The next such meeting has been loosely set for the early part of December 68.

F. Life Support Section (Protective Equipment and Training)

1. This area of responsibility and activity is being extensively reviewed and reorganized by Capt [redacted] with the assistance of [redacted] When completed, it will be integrated into the basic SOP for the conduct of all aeromedical office affairs. It should be moved in this connection that in the reorganization of the complete OSA - Aeromedical set-up, only one additional personnel space was requested (informally) and this to cover a physiological training officer for assignment to Edwards N. Base. The Commander of the Base informally concurred in the requirement for this addition to his aeromed section but would not provide a space from within his own allotment for such. The need for this additional officer will continue and will doubtless increase considerably over the next 3-6 months period, but it appears unlikely that this additional allocation will be validated at Hq OSA unless formal justification for such is submitted by the CFS, OSA-AO.

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G. Informal Liaison with Life Sciences Section of O. R. D.

1. Over the past 6 years, informal coordinating meetings have been carried out between OSA aeromed personnel and Life Sciences R&D personnel from ORD under [redacted] These conferences have served a dual purpose of keeping ORD fully cognizant of operational aeromedical problem areas and on the OSA side, keeping the aeromed group informed on new and potentially useful spin-offs from on-going R&D programs.

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25X1A

2. [redacted] OSA Chief Flight Surgeon, has been in contact with [redacted] and will arrange a future meeting to discuss common areas of interests and activities with [redacted] and his staff at a mutually agreeable time and date. Meanwhile, a short summary of these past conference topics of discussion will be prepared by the writer.

25X1A

25X1A

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[redacted]

Consultant
Aerospace Medicine

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OSA-3204-68

18 October 1968

MEMORANDUM FOR: Registry Branch, OSA

THRU: Executive Officer, OSA

SUBJECT: Distribution of Incoming Messages and Correspondence to the Aeromedical Staff

1. The Aeromedical Staff/OSA (AMS/OSA) became effective 14 October 1968. Until permanent offices are ready for occupancy, the AMS is located within D/R&D/OSA offices.

2. Incoming messages and correspondence containing the following slugs or individual's names should have action and/or information copies, as applicable, routed to AMS:

A. Aeromedical Staff (AMS)
B. Life Support
C. Medical
D. 25X1A
E.
F.
G.

3. Messages with an [redacted] contain sensitive medical information and will be distributed, eyes only, to D/SA, DD/SA and [redacted] 25X1A 25X1A

4. Messages slugged for Ops, D/M, R&D, or CMD/COMPT which have to do with the following subjects/information should have information copies routed to AMS:

A. Life Support and Survival Equipment, such as:

1. S-1010 PPA, Partial Pressure Suits
2. Seat Kits
3. Ejection Seats, Parachutes
4. Oxygen systems
5. Helmets, masks, regulators
6. Life Support AGE
7. Survival equipment, general
8. Life rafts
9. Emergency radios, beacons
10. Air Conditioning, pressurization

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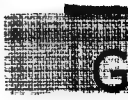

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31 JUL 1969

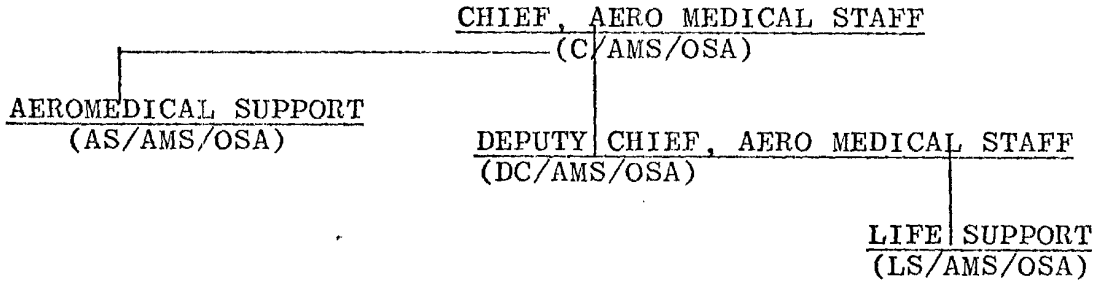
AERO MEDICAL STAFF

OFFICE OF SPECIAL ACTIVITIES

I. MISSION STATEMENT

AMS/OSA is responsible to the Director, Special Activities for the aeromedical aspects of OSA, DD/S&T operations, training, research and development. The function of the Aero Medical Staff is to insure that the operational aircrew member is properly evaluated and selected; that his health, both physical and mental, is maintained at peak effectiveness; and that his personal protective, survival, escape, and evasion equipment and training are up-to-date and satisfactory so that the aircrew member can participate effectively in attaining OSA mission objectives.

II. STAFF RESPONSIBILITIES



A. CHIEF, AERO MEDICAL STAFF

C/AMS/OSA is responsible to D/SA for all aeromedical aspects of OSA, DD/S&T operations, training, research and development. The C/AMS/OSA is solely responsible for the Aero Medical Support functions of AMS activities (i.e., AS/AMS/OSA).

Duties of Chief, AMS/OSA

1. Coordinate with and be knowledgeable of activities of Physiological Training Officer and M/Sergeant in charge of Escape and Evasion, drown proofing and para-sail training who form Life Support Division of AMS.

2. Coordinate with Agency Office of Medical Services (OMS) and Surgeon General's Office, USAF, in selection and screening of Air Force personnel including pilots, and all other A.F. integrees.

3. Monitor selection of Agency personnel assigned to OSA.

4. Coordinate with Assessment and Evaluation Psychological Staff in selection and evaluation and Resistence to Interrogation Training (RTI).

5. Supervise activities of two Flight Surgeons, medical technicians, E&E training Sergeant and Personal Equipment (PE) section at Detachment G. Also have similar relationship [redacted] P.E. Section at Detachment H. 25X1A

6. Coordinate with and support deployments from Detachment G.

7. Have Liaison with [redacted] in selection, training, and medical support of [redacted] 25X1A 25X1A

8. Have Liaison with Lovelace Clinic Albuquerque, New Mexico where Special Project pilots receive annual physical examination.

9. Relate to OSA Aerospace Medical consultant, DDS&T - ORD Aeromedical personnel, USAF School of Aerospace medicine, Lockheed Medical Dept, etc.

B. DEPUTY CHIEF, AEROMEDICAL STAFF

The DC/AMS/OSA is responsible, in the absence of the C/AMS/OSA, to the D/SA for all aeromedical aspects of OSA,DD/S&T operations, training, research and development. In addition, the DC/AMS/OSA is specifically responsible for the administrative aspects of AMS/OSA activities. The DC/AMS/OSA also directs the Life Support functions of AMS activities (i.e., LS/AMS/OSA).

C. LIFE SUPPORT (PROTECTIVE EQUIPMENT AND TRAINING)

The Life Support function of AMS/OSA insures that operational aircrews have the most advanced and applicable life support equipment and training required for the aircrew to fulfill the OSA mission. Life Support equipment includes: pressure suits; survival, escape, evasion, and rescue equipment; ejection seats and parachutes; and oxygen equipment. LS/AMS/OSA insures that such equipment: is properly developed, tested and evaluated; is properly utilized; is adequately maintained, overhauled, modified as required, and replaced when necessary. LS/AMS/OSA also insures that operational aircrews receive adequate training in the use of their life support equipment, and procedures and techniques for protection, survival, evasion, resistance and escape. The Life Support function is staffed by the following personnel with duties as indicated:

1. Aerospace Physiologist/Life Support Officer

a. Initiates and monitors research and development programs in the life sciences area as applicable to high performance manned aircraft.

b. Performs necessary research and development of life support equipment, ejection seats, parachuts, pressure suits and oxygen equipment.

c. Contracts for the development of personal equipment required to fulfill the mission, and monitors and closely coordinates industrial contractor efforts in research and development of life support equipment.

d. Directs and monitors field level life support programs with respect to:

(1) Procedures employed for supporting aircrews and their personal protective and survival equipment.

(2) Equipment utilization, test, and maintenance.

(3) Providing specifications for the acquisition of new, improved, modified or replacement items.

(4) Training of aircrews in aviation physiology, personal equipment and survival.

e. Performs frequent visits to field level life support sections to coordinate, inspect and assess their activities.

f. Participates in the indoctrination and training programs of the field level life support sections.

g. Participates in accident investigations as required.

h. Supplements field life support personnel during deployments if required.

i. Monitors activities of the Air Force and other services in the field of personal equipment, ejection seats, survival equipment, and parachutes.

j. Personally participates in environmental testing of experimental life support equipment.

k. Serves as contract technical monitor for all life support contracts, coordinating closely with CMD/Compt/OSA, D/M/OSA and Depot.

l. Writes technical and status reports on all the above.

m. Participates regularly in altitude chamber flights as inside observer to maintain proficiency.

2. Evasion and Survival Superintendent

a. Plans and organizes survival activities: Develops and improves procedures for instruction of aircrews in survival techniques.

b. Directs survival activities: Monitors lectures, demonstrations, and briefings on survival, evasion, resistance, and escape techniques to determine quality of instruction and effectiveness of training aids.

c. Inspects and evaluates survival and rescue programs to determine compliance with directives and policies. Examines rescue and survival equipment to determine adequacy and readiness for use in environments such as arctic, desert, mountain, tropical and water areas. Evaluates rescue/recovery techniques employed by rescue/recovery personnel.

d. Tests and evaluates parachutes and aerial recovery equipment techniques.

e. Conducts liaison with military and Agency personnel concerning survival, evasion, escape and recovery.

f. Designs and develops survival equipment and techniques in conjunction with appropriate Agency organization.

g. Coordinates all plans for covert activity with counterintelligence staff.

h. Parachutes frequently and regularly to maintain proficiency.

D. Aeromedical Support

Conducts medical examinations of flying personnel, engages in aerospace medicine and research, plans and administers medical service programs including maintenance of health standards, and conducts training of aeromedical nurses and technicians.

Duties and Responsibilities

1. Medical examinations - Applies the finest diagnostic abilities and compiles and evaluates data to determine physical and mental fitness to fly.

2. Aerospace Medicine Research - Studies physiological effects on the body of diversified flight conditions. Studies acute or chronically induced stress of flying whether it be the result of prolonged physical, physiological or psychological stress.

3. Coordinates Medical Service Programs - Develops policies and procedures governing medical aspects of flight, protective and survival equipment and accident prevention. Observes mental and physical condition of aircrew personnel. Investigates hazardous effects of toxic substances on flying and ground-crew personnel.

E. Aero Medical Consultant

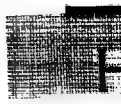
The Aero Medical Consultant will provide professional advisory services to the Chief, Aero Medical Staff (C/AMS) in the Life Sciences and R&D areas. These services will include but are not limited to the following:

1. Validation of biomedical, psychologic and psychiatric criteria for selection of special project operator personnel.

2. Delineation of new and potentially useful medical and/or psycho physiological tests and procedures to the now existent selection test battery.

3. The modification and control of human behavior and performance during routine and contingency operations.

4. Development of "portable" unit to determine indices of dynamic psycho physiologic fitness in the field.



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OFFICE OF SPECIAL ACTIVITIES
PROJECT HEADQUARTERS DIRECTIVE
NO. 1-5-1

ORGANIZATION
20 JULY 1966

ORGANIZATION - OFFICE OF SPECIAL ACTIVITIES

1. A reorganization of the various Divisions and Components within the Office of Special Activities has been effected as of this date. This reorganization affects both Headquarters and Field Units and has been approved by the DD/S&T. Approval of the slots noted on the organization charts by name and the authorized grade for each slot is still being reviewed by DD/S&T, and we expect approval in the near future.

2. Copies of the new organization reflecting these changes and the overall structure of the Office of Special Activities are attached.

25X1A

JOHN PARANGOSKY
Acting Director of Special Activities

Attachments -
As Stated

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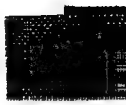

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I. Aero Medical Staff -- Input in Pilot Selection, Training and Qualification

A. Life Support:

Pressure Suit - Measurement, Fitting, Training

1. Measurement: Approximately ½ day per pilot at David Clark Company, Worcester, Massachusetts. Generally conducted when project Pilot is on East Coast for signing of contract (i.e., as early in the schedule as possible).

2. Fitting: Conducted generally as soon as equipment is completed and prior to the pilot starting checkout in the U-2 Aircraft.

a. Partial Pressure Suit (for use in U-2C/G Aircraft only). Production time from date of measurement to date of delivery is generally six (6) weeks. 1½ - 2 days per pilot is used for fitting at the David Clark Company, Worcester, Massachusetts.

b. S-1010 Pilot's Protective Assembly ("full pressure suit" for use in the U-2R Aircraft only). Production time from date of measurement to date of delivery is generally 16 weeks. 1½ - 2 days per pilot is used for fitting at the David Clark Co., Worcester, Massachusetts.

3. Training - Altitude Chamber Indoctrination Conducted as soon as possible after suit fitting, prior to the pilot starting checkout in the U-2 Aircraft. The altitude chamber flight is used to train the pilot in the protective aspects of his equipment to instill confidence and to confirm that the fit and comfort of the equipment is completely satisfactory.

a. Partial Pressure Suit: Training generally conducted at various USAF Physiological Training Units (Edwards AFB, Castle AFB) by Detachment and Headquarters' life support personnel, may also be conducted at Detachment G if scheduling permits (Det G has altitude chamber but does not have proper personnel to utilize it unless supplemented by Headquarters' personnel. One (1) day per pilot is required.

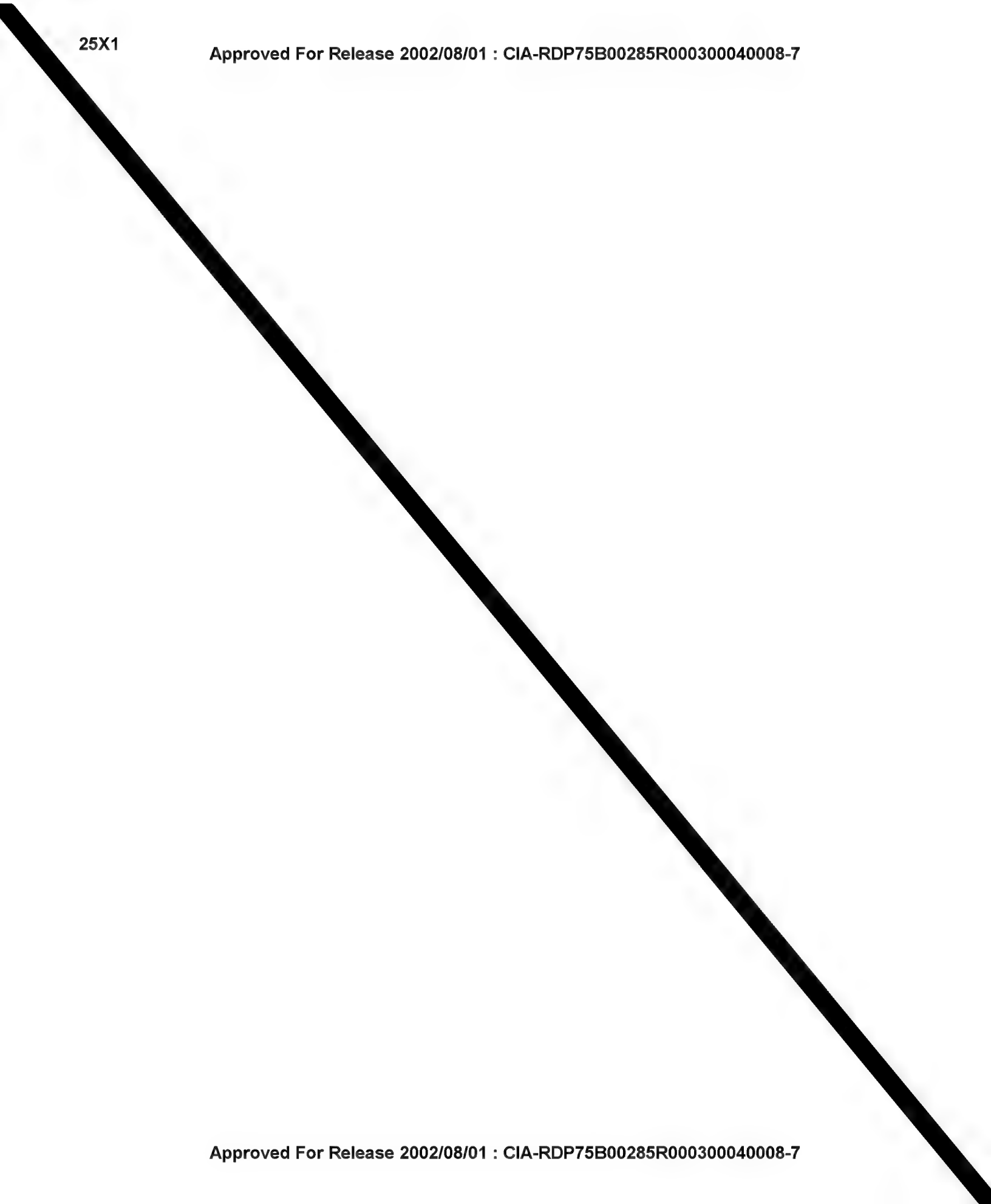
b. S-1010 PPA: Training is conducted in the altitude chamber located at the ARO Corp., Buffalo, N.Y. One (1) day per pilot is required.

NOTES:

Partial Pressure Suit: This equipment, consisting of custom-fitted suit and coverall and standard USAF partial pressure helmet is only compatible with the ejection seat/oxygen system/seat kit/parachute of the smaller cockpit of the U-2C/G Aircraft. Physiologically the partial pressure suit maintains the total pressure on the pilot equal to 40,000 feet altitude should cabin pressurization fail at flight altitudes above 40,000 feet. 100% oxygen is breathed which gives the pilot a 10,000 ft equivalent oxygen level. Flight in the U-2C/G Aircraft without the par tial pressure suit is limited to an altitude of 45,000 ft maximum. The outer coverall is made of flame resistant material for flash fire/crash fire protection. The equipment does not incorporate flotation or survival

(water or otherwise) features, therefore such capabilities must be "added on" to the pilot (i.e., wearing underarm life preservers, survival clothing in kit/cushion etc.). The primary limitation of the partial pressure suit in both the uninflated and inflated state is fatigue produced by the required tight fit and by circulatory effects when the suit is inflated for extended periods.

S-1010 PPA: This custom-fitted garment incorporates pressure protection, flotation, survival protection, fire protection, underwater-breathing capability, urine-elimination system, and ventilation capability in one garment which can be worn indefinitely uninflated and for extended periods when inflated. This equipment is only compatible with the life support systems in the U-2R. The pressure protection maintains the pilot at an altitude equal to 35,000 feet should cabin altitude exceed this level. 100% oxygen is breathed which gives the pilot a sea-level equivalent oxygen level.



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work together to find a mutually acceptable schedule to

25X1 ccomplish [redacted] along with other training requirements.

C. Medical Screening and Selection

1. Review of Medical Records: AMS/OSA and USAF Surgeon General's Office review medical records of those pilot candidates selected by D/O/OSA review. The medical records are obtained by AMS/OSA through USAF SGO as soon as the list of candidates is received.

2. Initial Physical Examination: Candidates who show no disqualifying defects upon review of medical records are scheduled immediately for a Space Pilot-type examination at the USAF School of Aerospace Medicine, Brooks AFB, Texas (1 week)

3. Washington, D. C. Assessment and Evaluation Program: After a full field security clearance has been obtained, the candidates are brought to Washington, D. C. in a local hotel, for 3 to 4 days.

25X1 [redacted]

b. Psychiatric Interview by a staff Psychiatrist from HQ's Staff OMS (1 hour)

c. AMS/OSA Flight Surgeon, Field Flight Surgeon (Det G), and possibly an Aerospace Medical Consultant apply an adaptability rating to each candidate through interviews and social contacts. ARMA (Adaptability Rating, Military Aircraft) screening procedures are used.

d. Review of USAF School of Aerospace Medicine Physical examination results is conducted.

4. Section of Project Pilots

a. A conference is held by those involved in the Assessment and Evaluation Program at which time the required number of pilots are selected from the available candidates.

b. One or more pilots thus selected are then interviewed by PD/Compt, SS/OSA and AMS/OSA. During this interview the selectee is given a gradual introduction to the Program, phased in a manner which allows him to "opt out" any time. If no problems arise, he is then briefed and offered a job as a project pilot.

5. ANNUAL PHYSICAL EXAMINATION

After selection there is no further medical input into initial qualification of the project pilot. Each project pilot receives an annual physical examination at the LOVELACE CLINIC, Albuquerque, New Mexico, (Approximately 1 week) however, this is not part of his initial qualification.

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Given to Bill F 15 Apr 69

SECRET

Aeromedical Personnel

1. Detachment G -- [redacted] (USAF) 25X1A

[redacted] 25X1A

A. This is the minimum number in each category required to perform the necessary aeromedical/life support functions at Detachment G. The only change (reduction) that could be tolerated would be a cut of 2 personal equipment technicians if all U-2C/G flying activities were eliminated. As long as even a single U-2C/G flies at Det G, the pilots personal equipment and aircraft life support equipment must be maintained at the same level as at present.

B. Conversion from USAF personnel to civilian contract employees.

If the entire detachment's military contingent were eliminated, all aeromedical/life support personnel could be converted. However, if some or all of the present military contingent remains, the flight surgeon and one of the medical technicians slots should remain military. All personal equipment slots and the rescue and survival technicians slot could be converted to civilian contract. They should not be converted to "tech reps" for a given company (i.e., ARO, David Clark or Lockheed). A mixed force of USAF and civilian contract employees would be less desirable but manageable.

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2. [redacted] 25X1A

A. This obviously is a minimum. It is very desirable that [redacted] be converted to a civilian 25X1A contract employee. All things considered, the function would be improved by such a change. 25X1A

3. [redacted]

A. This is a minimum and, as far as the requirement is understood, [redacted] 25X1C

4. [redacted] 25X1A

A. This is an absolute minimum and the types of personnel should be retained.

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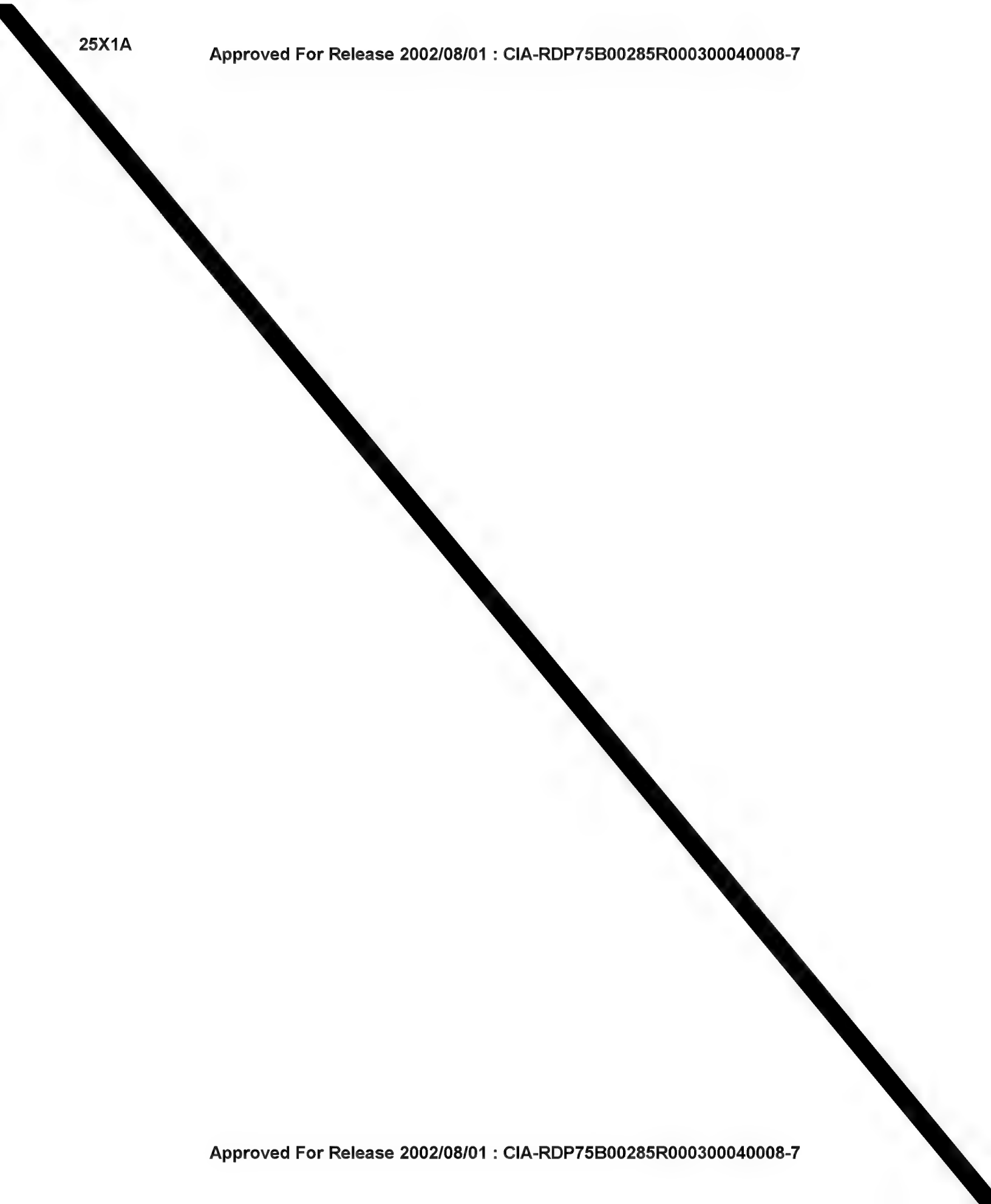

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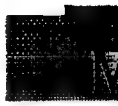

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DAVID CLARK COMPANY

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Current Engineering Tasks

A. Improved Face Barrier

B. U.C.D. Valve clamp

C. Parachute Harness Sling Retention

D. Improved Comm. Cord Reliability

E. Improved Cold water protection

F. Life Raft Improvement (shared program)

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ARO CORPORATION

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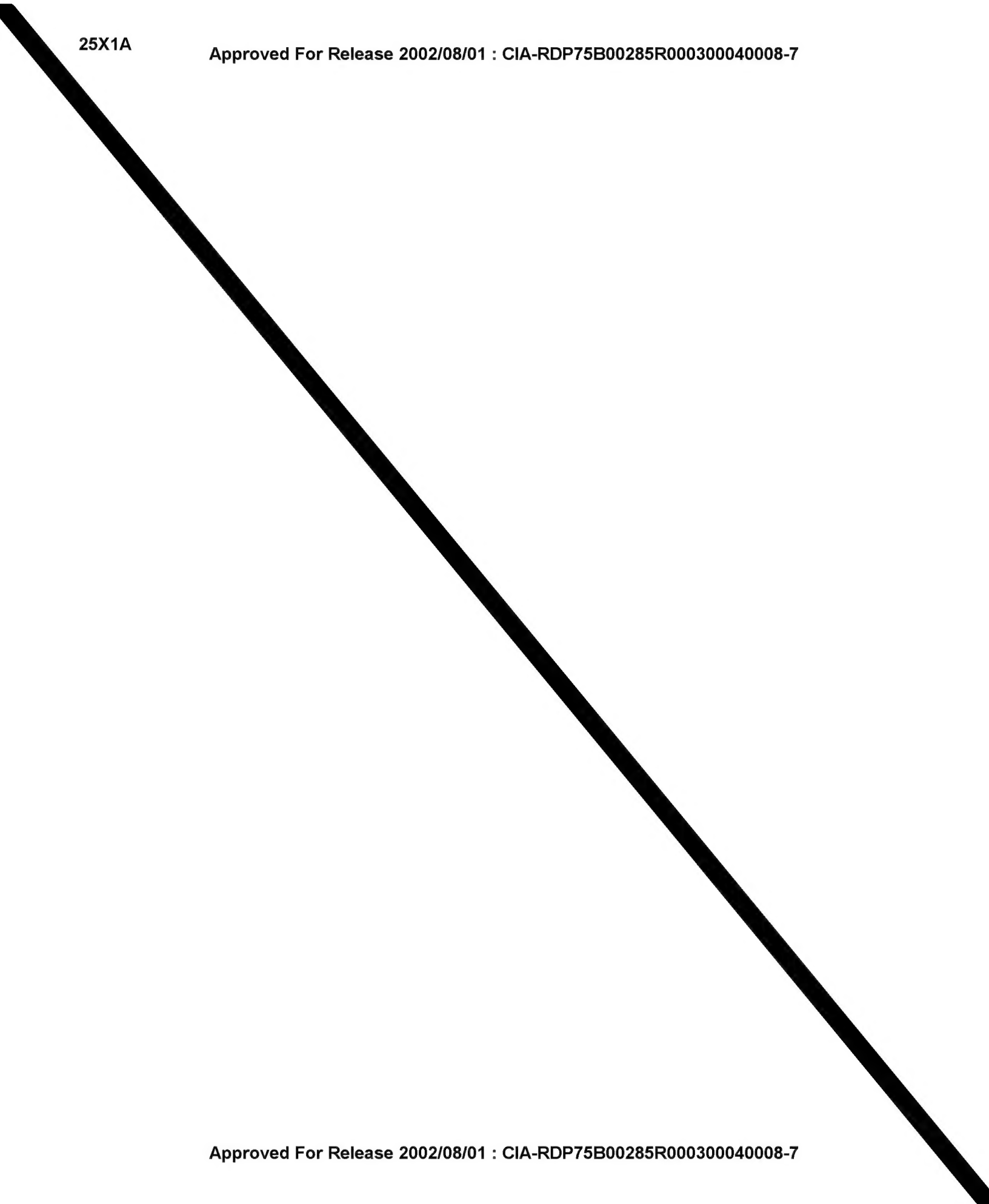

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